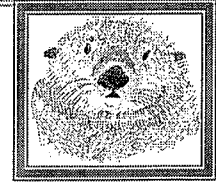


2<sup>nd</sup> & 3<sup>rd</sup> YEAR RESIDENTS  
3<sup>rd</sup> & 4<sup>th</sup> YEAR STUDENTS  
2<sup>nd</sup> YEAR PHYSICIAN ASSISTANTS

4-6-8 WEEK ROTATIONS



Thank you for your interest in our program!

The Student/Resident Program is designed to introduce Students and Residents to the ANTHC, IHS and Tribally operated programs. Over 300 Students and Residents work as volunteers at ANTHC each year; hundreds more apply.

To help assure a positive learning experience, careful coordination of assignments is required. It is our sincere hope that through this program you will find a future employment opportunity and join us in serving Alaska Natives and Native Americans.

#### **QUALIFICATIONS – REQUIREMENTS / PROCEDURES**

- This program is limited to Residents that have successfully completed their 1<sup>st</sup> year of Residency  
Medical Students in their 3<sup>rd</sup> or 4<sup>th</sup> Year  
Physician Assistant Students in there clinical phase of training from programs approved by the American Academy of Physician Assistants
- You may apply a minimum of 3 months in advance and as early as a year in advance.
- Your assignment will be canceled if you are on probation or your license is restricted.
- The Alaska Native Tribal Health Consortium is not a J-1 or H-1 visa sponsor, **therefore visa holders are not recruited by this program.**

#### **ASSIGNMENTS**

- These are voluntary work assignments. No stipend is paid. You will have call and some days off.
- Housing is usually provided for Residents (Anchorage and Juneau are exceptions).
- Assignments scheduled are based on:
  - completeness of application
  - references
  - recruiting potential
  - location/time preferences
  - professional education
  - statement of your future professional plans
- Cancellations do occur, and at your request we will place you on a waiting list.
- Please read the enclosed site descriptions to determine your preference.

## **APPLICATION**

All sections of the application must be **received and completed** before applicants can be considered for placement/referral.

**Please send your application to:** Attn: Professional Recruiting Services, 4831 Old Seward Hwy, Suite 107 Anchorage, Alaska 99508

**You must fill out the application in its entirety to be considered for a rotation.**

- ☐ **Application** (signed and completed)  
To include: -Privacy Act Statement -Release of Information -Housing/Meals -Travel Notice  
-Child Care & Indian Care Worker Positions -Liability Form -CME
- ☐ **Curriculum Vitae-resume** (attach a current (CV) and any Personal Statements or Special Requests)
- ☐ **Letter from your program**

**Students – A letter of recommendation from your Dean stating that you are in “Good Standing”.**

**Residents – A letter of recommendation from your Residency Program Director stating that you are in “Good Standing” and specifically addressed to ANTHC Recruiting with appropriate identification of student and proof of malpractice coverage is required.**

**Two (2) additional letters of recommendation**

**Residents – Other MD’s with whom you are participated in clinical rotations and are familiar with your clinical skills.**

**Students – MD’s or professors who know you and of your clinical skills.**

- ☐ **\* Medical/Resident License\***

**DO NOT APPLY FOR A LICENSE UNTIL YOU HAVE BEEN ACCEPTED FOR A ROTATION.**

The State of Alaska has the authority to conduct a discretionary interview between the Residents assigned to participate in a rotation and the State Medical Board or an appropriate State Representative, at any time.

All Residents are required to have a current valid Alaska Resident License.

**Supply a copy of ALL your Resident License(s). (If you do not have an Alaska license, please submit proof of having applied for it once accepted for your rotation.)**

**TO APPLY:** Download the application from the State of Alaska’s web site at

<http://www.dced.state.ak.us/occ/>

**\*It will take approximately 2 months to obtain your resident license.**

**FOLLOW-UP ON APPLICATION:** Call (907) 265-2541 or the State of Alaska’s web site to check on the status of your license application.

It is your responsibility to obtain a license in a timely manner and prior to the beginning of your rotation. The site that selects you for a rotation may pay and/or reimburse the fee. You will need to check with the site you will be providing your rotation at.

- ☐ **Copy of your Medical School Diploma (if applicable)**
- ☐ **Copies of any completed certificates of internship/residency (if applicable)**
- ☐ **Immunization History**  
Residents receiving assignments must file with us evidence of immunity to:  
o Hepatitis B o Rubella o Rubeolla o and documentation of a negative PPD, **6 months** prior to assignment.

**TRAVEL:** Contact the site that selected you before purchasing a ticket; some sites will consider funding your full travel or half the travel.

## **EVALUATION**

Your preceptor at the site must complete evaluations of your performance. You will be informed of the site's contact information after your acceptance.

## **OPPORTUNITIES**

**Contact:** **Statewide Professional Recruiting at 800-528-6680** in the fall of your last year of Residency if you are interested in long-term practice opportunities. Many of our physicians participate in the IHS Loan Repayment Program. This program pays up to \$20,000 per year for a 2-year commitment in addition to a competitive salary.

We take great pride in our health care system and this is our opportunity to share the experience with you. Good luck!

## STUDENT / RESIDENT APPLICATION

### ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

Statewide Professional Recruiting Services  
Student/Resident Program  
4831 Old Seward Hwy, Ste 107 Anchorage, AK 99503  
800-528-6680 - (907) 729-3633  
[www.anthc.org](http://www.anthc.org)

**Below is a list of facilities that are participants in the Statewide Recruiting Program for Students/Residents. The information you provide in and with this application and all subsequent verifications received may be shared with one or all of these facilities.**

Alaska Native Medical Center - Anchorage	Norton Sound Health Corporation - Nome
Annette Island Service Unit - Metlakatla	Samuel Simmonds Memorial Hospital - Barrow
Bristol Bay Area Health Corporation - Dillingham	South East Alaska Regional Health Consortium Medical Clinic - Juneau
KIC Tribal Health Clinic - Ketchikan	South East Alaska Regional Health Consortium - Sitka
Maniilaq Health Center - Kotzebue	Yukon-Kuskokwim Delta Regional Hospital - Bethel

**APPLICATION INSTRUCTIONS:** Applicant must fill out the application in its entirety and include all required documentation in accordance with the instructions given in the application cover letter. Failure to do so will delay the referral process.

All information must be typed or clearly handwritten. (Applications that are not legible will be returned)

Referring to or writing "See Curriculum Vitae" or any other type of similar wording referring to another document may complete no part of the application. All parts of the application must be completed in their entirety.

**REMINDER:** Please be sure that all information requested on pages 1 & 2 are attached in support of this application.

If more space is needed, a blank sheet is provided for your convenience as page 13 of this application.  
When using the blank sheet, please make reference to the question being answered.

#### Personal Information

Last Name	First Name	Middle Name or Middle Initial	Pro Degree
Date of Application	<input type="radio"/> Student <input type="radio"/> Resident		Gender <input type="radio"/> Female <input type="radio"/> Male
Other Names By Which You Have Been Known Professionally			SSN:
Address		City/State/Zip	
Work Phone Number	Work Fax Number	Home Phone Number	
Date of Birth	Birth City/State	Birth Country	
Citizenship (ANTHC does not sponsor J-1 or H-1 Visa Holders):		Ethnic Origin	E-Mail Address

#### Rotation Information

TYPE OF ROTATION REQUIRED:	<input type="radio"/> Ambulatory	<input type="radio"/> Inpatient	<input type="radio"/> Either
LIST THREE SITES (in order of preference)	Required Specialty	List 3 Dates - 4/6/8 Weeks Beginning	
1.			
2.			
3.			
Are you a National Health Service Corps Scholar?	<input type="radio"/> Yes	<input type="radio"/> No	
Are you an Indian Health Service Scholar or Obligee?	<input type="radio"/> Yes	<input type="radio"/> No	
Are you Native American or Alaskan Native? (We give preference as required by law to NA & AN)	<input type="radio"/> Yes	<input type="radio"/> No	
Will you fund your own travel or do you have an alternate resource for travel funding?	<input type="radio"/> Yes	<input type="radio"/> No	
Without travel funding, will you cancel?	<input type="radio"/> Yes	<input type="radio"/> No	
Do your future plans include living in Alaska?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Maybe
Do your future plans include working for IHS?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Maybe

**Education and Training:** (IMPORTANT REMINDER: No part of the application may be completed by referring to or writing "See Curriculum Vitae". All parts of the application must be completed in their entirety.)

**COLLEGE EDUCATION:**

Name Of Institution		Start Date	Finish Date
Complete Address City, State, Zip			
Phone Number	Fax Number	E-Mail Address	Degree Obtained

**MEDICAL EDUCATION or PROFESSIONAL SCHOOL:**

If foreign medical school graduate, submit a copy of ECFMG.

(IMPORTANT REMINDER: referring to or writing, "See Curriculum Vitae" may complete no part of the application. All parts of the application must be completed in their entirety.)

Name Of Institution		Start Date	Finish Date
Complete Address City, State, Zip			
Type of training/specialty/major	Was program successfully completed? <input type="radio"/> Yes <input type="radio"/> No	If yes, what degree was awarded	Your Program Director
Current Program Director (if known)	Phone Number	Fax Number	E-Mail Address

Name Of Institution		Start Date	Finish Date
Complete Address City, State, Zip			
Type of training/specialty/major	Was program successfully completed? <input type="radio"/> Yes <input type="radio"/> No	If yes, what degree was awarded	Your Program Director
Current Program Director (if known)	Phone Number	Fax Number	E-Mail Address

**INTERNSHIP (if applicable):**

Name Of Institution		Start Date	Finish Date
Complete Address City, State, Zip			
Type of training/specialty/major	Was program successfully completed? <input type="radio"/> Yes <input type="radio"/> No	If yes, what degree was awarded	Your Program Director
Current Program Director (if known)	Phone Number	Fax Number	E-Mail Address

Name Of Institution		Start Date	Finish Date
Complete Address City, State, Zip			
Type of training/specialty/major	Was program successfully completed? <input type="radio"/> Yes <input type="radio"/> No	If yes, what degree was awarded	Your Program Director
Current Program Director (if known)	Phone Number	Fax Number	E-Mail Address

**RESIDENCY (if applicable)**

Name Of Institution		Start Date	Finish Date
Complete Address City, State, Zip			
Type of training/specialty/major	Was program successfully completed? <input type="radio"/> Yes <input type="radio"/> No	If yes, what degree was awarded	Your Program Director
Current Program Director (if known)	Phone Number	Fax Number	E-Mail Address

Name Of Institution		Start Date	Finish Date
Complete Address City, State, Zip			
Type of training/specialty/major	Was program successfully completed? <input type="radio"/> Yes <input type="radio"/> No	If yes, what degree was awarded	Your Program Director
Current Program Director (if known)	Phone Number	Fax Number	E-Mail Address

**Military Experience: List** all military experience that has occurred since completion of medical school or professional training. (IMPORTANT REMINDER: No part of the application may be completed by referring to or writing "See Curriculum Vitae". All parts of the application must be completed in their entirety.)

Reserve Status? ☐ Active ☐ Inactive ☐ None If Active, where assigned? \_\_\_\_\_

Military Branch	Last Title	Last Rank	Supervisor's Name	
Last Assignment/Facility Complete Address			Date of Assignment	Date of Separation
Phone Number	Fax Number	E-Mail Address	Type of Discharge:	
Military Branch	Last Title	Last Rank	Supervisor's Name	
Last Assignment/Facility Complete Address			Date of Assignment	Date of Transfer
Phone Number	Fax Number	E-Mail Address		

**Professional References:** Include the names of three individuals who can attest to your current clinical competence and professional performance. DO NOT INCLUDE current partners or relatives. The names that you provide must have the same type of professional license that you have, and the references must have had recent (within the past three years) exposure to your clinical practice. At least one of the references must be a program director from your current program.

Name of Reference		Reference's affiliation to you?
Complete Address		
Phone Number	Fax Number	E-Mail Address
Name of Reference		Reference's affiliation to you?
Complete Address		
Phone Number	Fax Number	E-Mail Address
Name of Reference		Reference's affiliation to you?
Complete Address		
Phone Number	Fax Number	E-Mail Address

**ID Numbers**

**State License(s):** List all current and past state licenses.

State of Licensure	Number	Type	Expiration Date
ALASKA			

**Other ID Numbers**

Type of Number	Number	Expiration Date (where applicable)
DEA Number		
UPIN Number		

BLS	Expires	ACLS	Expires	ATLS	Expires	PALS	Expires	NRP	Expires
<input type="radio"/> yes <input type="radio"/> no		<input type="radio"/> yes <input type="radio"/> no		<input type="radio"/> yes <input type="radio"/> no		<input type="radio"/> yes <input type="radio"/> no		<input type="radio"/> yes <input type="radio"/> no	

**Malpractice Coverage – Submit a copy of your current professional liability coverage “face sheet” showing coverage in your practice specialty.**

IF YOU ANSWER “YES,” PLEASE PROVIDE DETAILED INFORMATION ON A SEPARATE SHEET. IF YOU ANSWER YES TO QUESTION 1 OR 2, THEN PLEASE USE THE ENCLOSED PROFESSIONAL LIABILITY ACTION EXPLANATION FORM (PAGE 11 OF THIS APPLICATION)

1.	Has there ever been or are there currently, any claims, lawsuits, settlements or judgments against you where you are named as a responsible party, even if not resulting in monetary damages, or have you received any notice of “Intent to File”?	<input type="radio"/> Yes <input type="radio"/> No
2.	If you have been a federal or tribal contracted employee, have you ever been named as a responsible party in a lawsuit against the United States Government that resulted in a financial settlement or payment?	<input type="radio"/> Yes <input type="radio"/> No
3.	Have you ever had any professional liability insurance coverage canceled, declined or modified (i.e., reduced limits, restricted coverage), or has any renewal ever been refused, or have you voluntarily given up coverage?	<input type="radio"/> Yes <input type="radio"/> No

**Affiliations/Work History:** List all work history activities that are clinical or healthcare related since completion of your baccalaureate degree. Indicate affiliation status (Active, Courtesy, Provisional, Temporary, No longer on staff, etc.). Begin with current affiliations and then list past affiliations. (IMPORTANT REMINDER: No part of the application may be completed by referring to or writing, “See Curriculum Vitae”. All parts of the application must be completed in their entirety.)

Name of Institution			Supervisor's Name	
Complete Address			Start Date	Finish Date
Phone Number	Fax Number	E-Mail Address	Job Title	
Brief Description of Job Responsibilities				

Name of Institution			Supervisor's Name	
Complete Address			Start Date	Finish Date
Phone Number	Fax Number	E-Mail Address	Job Title	
Brief Description of Job Responsibilities				

**Explanation of Work History Gap:** Any time periods or gaps since graduation from medical school of greater than 3 months which are not explained in the application thus far, must be addressed here. If the application is found to have any unexplained time periods or gaps since medical school of greater than 3 months the application will not be processed and will be returned to the applicant as incomplete. Please explain any such gaps in the space provided below.

From Date	To Date	Explanation Of Work History Gap

**HEALTH STATUS**

IF YOU ANSWER “YES,” TO ANY OF THE QUESTIONS BELOW, PLEASE PROVIDE DETAILED INFORMATION ON A SEPARATE SHEET (see page 11, added for your convenience). INCLUDED SHOULD BE INFORMATION REGARDING THE NAME OF ANY INSTITUTION, ORGANIZATION, OR THEIR ENTITY AT WHICH ACCOMMODATION WAS MADE FOR THE CONDITION. INCLUDE THE NAME, ADDRESS, AND TELEPHONE NUMBER OF A KNOWLEDGEABLE PERSON AT THE HOSPITAL, ORGANIZATION, OR OTHER ENTITY AT WHICH ACCOMMODATIONS WERE MADE.

1.	Do you have an ongoing physical impairment or condition that would prevent you without reasonable accommodation, to perform the essential functions of your area of specialty without a direct threat to the health and safety of others? If yes, please describe in detail the accommodation needed on a separate sheet (see page 12, added for your convenience).	<input type="radio"/> Yes <input type="radio"/> No
2.	Do you have a history, including the present of mental illness or mental health condition that might adversely affect your ability to competently and safely perform the essential functions of a practitioner in your specialty?	<input type="radio"/> Yes <input type="radio"/> No
3.	Do you have any physical, mental or emotional conditions that might limit your ability to meet other duties associated with Medical Staff membership and which could require an accommodation for you to exercise your clinical privileges and Medical Staff duties completely and safely? If yes, please describe in detail the accommodation needed on a separate sheet (see page 12, added for your convenience).	<input type="radio"/> Yes <input type="radio"/> No

## DISCLOSURE QUESTIONS

**All "YES" or Pending answers require a full explanation on a separate page (see page 12, added for your convenience).**

IMPORTANT REMINDER: referring to or writing "See Curriculum Vitae" and/or "See Enclosed/Attached" may complete no part of the application.  
All parts of the application must be completed in their entirety.

Have there **EVER BEEN** on a **VOLUNTARY \*** and/or **INVOLUNTARY** basis any actions taken, or are currently in process of being taken, which resulted in or may result in: disciplinary action, revocation, stipulation, sanction, censure, written reprimand, restriction, non-renewal or denial of rights or privileges, suspension, reduction, limitation, placing on probation, required performance of public service, a course of education training, counseling or monitoring, resignation, leave of absence, withdrawal of an application, termination or non-renewal of a contract, relinquishment or non-renewal of any of the following:

**\* IMPORTANT NOTE:** A voluntary relinquishment or voluntary non-renewal should be reported when the relinquishment or non-renewal is done to avoid an adverse action, precludes an investigation, or is done while the licensee is under investigation related to professional conduct.

1.	Licensure in any state?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
2.	Other professional registration and/or license?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
3.	DEA/Controlled Substance Registration?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
4.	Membership in any hospital medical staff?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
5.	Have you ever been the subject of an informal or formal hearing process at any hospital?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
6.	Clinical Privileges?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
7.	Professional Society membership/fellowship?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
8.	Any other type of professional sanction?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
9.	Participation in any third party payer program?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
10.	Participation in Medicare/Medicaid program?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
11.	Research under any Federal or private grants?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
12.	Academic Appointment?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
13.	Have you ever been convicted of a felony?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
14.	Have you ever been convicted of a misdemeanor?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
15.	Do you have or have you had a diagnosed or undiagnosed chemical dependency (to include alcohol, illegal drugs, prescriptive drugs, etc)?	<input type="radio"/> Yes <input type="radio"/> No
16.	Are you using illegal drugs or abusing prescriptive drugs or alcohol?	<input type="radio"/> Yes <input type="radio"/> No

I represent that the information provided in or attached to this application is accurate. I understand that misrepresentation, misstatement, or omission from this application will cause rejection of this application and denial of privileges and/or a rotation. Evidence of false information will cause rejection or revocation of this application. I have agreed to abide by the Medical Staff Bylaws, rules and regulations, policies of the institution to which I may be assigned and agree that they will bind my activities as a resident accepted for a rotation at one of the facilities participating in the ANTHC Recruitment Program for Students/Residents. I understand that I may request a copy of the bylaws of each institution to which I might be assigned.

\_\_\_\_\_  
Signature (Stamped or representative signatures unacceptable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name

## Statement of Understanding, Attestation and Consent & Release from Liability

**Below is a list of facilities that are participants in the Statewide Recruiting Program for Students / Residents. The information you provide in and with this application and all subsequent verifications received may be shared with one or all of these facilities.**

Alaska Native Medical Center - Anchorage	Norton Sound Health Corporation - Nome
Annette Island Service Unit - Metlakatla	Samuel Simmonds Memorial Hospital - Barrow
Bristol Bay Area Health Corporation - Dillingham	South East Alaska Regional Health Consortium Medical Clinic - Juneau
KIC Tribal Health Clinic-Ketchikan	South East Alaska Regional Health Consortium – Sitka
Maniilaq Health Center - Kotzebue	Yukon-Kuskokwim Delta Regional Hospital – Bethel

In signing the application for Student / Resident appointment,

**I understand** and authorize the staff of ANTHC and the facility to which I will be assigned to release this acquired information to State Licensing Boards or Agencies of the Federal Government, or other similar entities at their discretion.

**I release** from liability all those that provide information to ANTHC and the facility to which I will be assigned in good faith and without malice in response to our inquiries.

**I understand** and authorize the staff of ANTHC to release any requested information to their affiliated hospitals. I understand that ANTHC and affiliated hospital to mean all the facilities listed at the top of this form.

**I certify** that the answers to the foregoing questions are true to the best of my knowledge, and that the statements I have made in connection with this application, interview, and my CV/resume are also true. I have not omitted anything, which might be important to ANTHC and the facility to which I will be assigned in deciding to accept me for a rotation.

**I understand** that any misstatements in, or omissions from this application may constitute cause for summary revocation of my appointment and privileges and termination of my employment. All information submitted by me on this application is true to the best of my knowledge and belief.

**I authorize** ANTHC and/or its agents and the hospital and its medical staff and/or their representatives to consult with other persons, hospitals, associations, institutions, and malpractice carriers that I have been associated with to ascertain information which may be pertinent to my application, including, but not limited to:

- professional education, training and experience
- clinical competence
- malpractice history
- military and police records
- ethical qualifications
- medical records as they pertain to Quality Assurance
- records and documents, including medical records at other hospitals as they pertain to Quality Assurance
- OIG/GSA Reports
- My Health Status as it pertains to my ability to practice safely

**I hereby** release from liability all representatives of the Alaska Native Tribal Health Consortium and the representatives of the facility to which I am accepted and its professional staff for all acts performed in good faith and without malice in connection with evaluating my application, credentials, and professional qualification. I am willing to appear in person to discuss any matters related to this application.

**In making** application for a rotation to further my training through the Alaska Native Tribal Health Consortium, and its affiliated facilities, I acknowledge that I have received a copy of the medical staff by-laws, rules and regulations, and agree to abide by them.

**NOTE:** Photocopies and/ or facsimile copies of this Authorization will serve the same purpose as the originally executed document.

\_\_\_\_\_  
Signature (Stamped or representative signatures unacceptable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name

**PRIVACY ACT STATEMENT**

Section 1104, and 3301 35 sec. of title 5 of the U.S. Code authorize collection of this information. The employee identification number is your Social Security Number (SSN); Executive Order 9397 authorizes collection of this information. The Public Health Service may use your SSN to make requests for information about you from employers, schools, banks, and others who know you, but only as allowed by law or Presidential directive. The information we collect by using your SSN will be used for purposes of the Student Program and perhaps employment purposes and also for studies and statistics that will not identify you. Information we have about you may also be given to Federal, State, and local agencies for checking on law violations or for other lawful purposes. Furnishing the information on this form, including your SSN, is voluntary. However, we cannot process your application for the Student and Resident Program, if you do not give us the information we request.

---

Your Signature

---

Date**FALSE STATEMENT NOTIFICATION**

A false statement may be grounds for not hiring you, or for firing you if you have already begun work. Also, you may be punished by fine or imprisonment. (Section 1001 of title 18, United States Code).

---

Your Signature

---

Date**HOUSING/MEALS**

The Student and Resident Program cannot guarantee that housing or meals will be provided for Students or Residents at the selected sites. If a site cancels housing or meals it is not under our control.

---

Your Signature

---

Date**TRAVEL NOTICE**

The Student and Resident Program cannot guarantee paid travel for your assignment. We do not reimburse travel expenses including the purchase of tickets, itinerary changes, exchanges, or loss of tickets by the traveler.

---

Your Signature

---

Date

# ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

Office of Human Resources  
4000 Ambassador Drive  
Anchorage, Alaska 99508  
Telephone: 907 729-1301  
Facsimile: 907 729-3638



## DECLARATION FOR EMPLOYMENT INDIAN CHILD PROTECTION ACT (PL 101-630)

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

### BACKGROUND INFORMATION

*Section 408 of the Indian Child Protection and Family Violence Prevention Act of 1990*

Public Law 101-630 requires an investigation of the character of each individual who is employed, or is being considered for employment, in a position with duties and responsibilities that involve regular contact with or control over Indian Children.

*Section 231 of the Crime Control Act of 1990*

Public Law 101-647 requires those employment applications for childcare positions have applications sign a receipt of notice that a criminal record check will be conducted. The check shall include a search of the criminal history repositories of all states that an employee or prospective employee lists as current and former residences in an employment application.

I certify that my response to these questions is under Federal penalty of perjury, which is punishable by fine or imprisonment, and that I have received notice that a criminal check will be conducted. I understand my right to obtain a copy of any criminal history made available to Alaska Native Tribal Health Consortium and my rights to challenge the accuracy and completeness of any information obtained in the report.

### PLEASE MAKE SURE BOTH QUESTIONS ARE ANSWERED

1. Have you ever been arrested for or charged with a crime involving a child? ☐ Yes ☐ No

If "YES", provide the date, explanation of the violation, disposition of the arrest or charge, place of occurrence, and the name and address of the police department or court involved.

---

---

---

---

2. Have you ever been found guilty of, or entered a plea of no contest (nolo contendere), or guilty to, any felonious offense or any of 2 or more misdemeanors offenses under Federal, State, or tribal law involving crimes of violence; sexual assault, molestation, exploitation, contact or prostitution; crimes against persons; or offenses committed against children? ☐ Yes ☐ No

If "YES", provide the date, explanation of the violation, disposition of the arrest or charge, place of occurrence, and the name and address of the police department or court involved.

---

---

---

---

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Professional Liability Action Explanation Form

This form must be completed if you answered "yes" to question #1 on page 4

Please complete this form for each pending or settled professional liability action or any payment made on behalf of applicant. All questions must be answered completely. If additional sheets are required, please photocopy this page prior to completing. Please provide us with a separate sheet for each malpractice action.

### Please Print

Date of Alleged Incident	Date Suit Filed
Patient Name	Location of Incident
Your Relationship to Patient (Attending Provider, Surgeon, Assistant Surgeon, Consultant, etc.)	
Allegation	
Liability Carrier when Incident Occurred	
Additional Named Responsible Parties/Defendant(s)	

### Claim Status

<input type="radio"/> OPEN – If open, amount being sought			
<input type="radio"/> CLOSED – If closed, indicate method of closing	<input type="radio"/> Dismissal	<input type="radio"/> Settlement	<input type="radio"/> Judgment
Amount of settlement or judgment			
Summarize the circumstances giving rise to the action. If the action involves patient care, describe a narrative, which provides your care and treatment of the patient. If additional space is necessary, attach adequate clinical detail to allow proper evaluation by a committee of physicians. Include: 1) Condition and diagnosis at time of incident, 2) dates and description of treatment rendered and 3) condition of patient subsequent to treatment. <b>Please print.</b>			

### SUMMARY


I certify that the information in this document and any attached documents is true, correct and complete. I agree that ANTHC and the facility (ies) to which I am assigned for a rotation, its representatives and any individuals or entities providing information in good faith shall not be liable for any act or omission related to the evaluation or verification contained in this document, which is part of the application which I am submitting to ANTHC. I further agree to notify ANTHC of changes to the information included in this form.

\_\_\_\_\_  
Name (please print or type)

\_\_\_\_\_  
Practitioner Signature

\_\_\_\_\_  
Date

Section being referenced: \_\_\_\_\_ Explanation: \_\_\_\_\_

---

---

---

---

---

---

---

Section being referenced: \_\_\_\_\_ Explanation: \_\_\_\_\_

---

---

---

---

---

---

---

Section being referenced: \_\_\_\_\_ Explanation: \_\_\_\_\_

---

---

---

---

---

---

---

Section being referenced: \_\_\_\_\_ Explanation: \_\_\_\_\_

---

---

---

---

---

---

Section being referenced: \_\_\_\_\_ Explanation: \_\_\_\_\_

---

---

---

---